FY 2001 BUDGET AND PERFORMANCE REQUIREMENTS
JUNE 12, 2000

Intermediaries

Medicare Integrity Program

Medical Review
Medicare Secondary Payer
Benefit Integrity
Audit
Provider Education and Training

MEDICARE INTEGRITY PROGRAM

Medical Review (Intermediary)

The Medical Review (MR) Budget and Performance Requirements (BPRs) reflects the principles, values, and priorities for the Medicare Integrity Program (MIP). Program Integrity's primary principle is to pay claims correctly. In order to meet this goal intermediaries must ensure that they pay the right amount for covered services rendered to eligible beneficiaries by legitimate providers. HCFA follows four parallel strategies that assist us in meeting this goal: 1) preventing inappropriate payments through effective enrollment and through education of providers and beneficiaries; 2) early detection through, for example, medical review and post-pay data analysis; 3) close coordination with our partners, including contractors and law enforcement agencies; and 4) fair and firm enforcement policies.

The MR BPR also supports the Government Performance Results Act (GPRA) and the National Performance Review (NPR). The GPRA requires that intermediaries reduce the error rate identified by the Office of Inspector General's Chief Financial Officer (CFO) audit, and reduce the Home Health error rate. Both the GPRA and NPR instruct intermediaries to increase the effectiveness and improve the efficiency of medical review.

The MR Budget and Performance Requirements form the basis of the Contractor Performance Evaluation (CPE) for MR units. The CPE core standards support HCFA's Program Integrity strategy. HCFA's national objectives and goals of the CPE are as follows: 1) Increase the effectiveness of medical review activities; 2) Exercise accurate and defensible decision making on medical reviews; 3) Effectively educate and communicate with the provider and supplier community; 4) Collaborate with other internal components and external entities to ensure correct claims payment, and to address situations of fraud, waste, and abuse. Therefore, intermediary budget requests should ensure implementation of all MR program requirements in the Program Integrity Manual in addition to those specified in this document.

Each intermediary should provide the ***supporting documentation in Attachment 3*** of the FY 2001 BPRs.

Medical Review Program Goals and Directions

Medical Review Program Point of Contact

An effective Medical Review program begins with the strategies developed and implemented by senior management staff. Intermediaries must name a medical review point of contact that will act as the primary contact between the intermediary and HCFA concerning the intermediary's entire medical review program. Although intermediaries have the discretion to title this position however they choose, for purposes of this document the individual shall be called the "MR Manager".

Quality Improvement Program

The intermediary must assure the implementation of an effective Quality Improvement Program. The intermediary must develop and implement a Quality Improvement (QI) program to assure that the decisions made by medical review staff are accurate and consistent among MR staff. The QI program requires physician participation to determine the accuracy of medical review decisions. Inter-reviewer reliability and accuracy is a critical portion of the QI program. The QI program must test and improve inter-reviewer reliability. The program must assure a thorough and efficient medical review process. The QI program must include a documented process for the review of complex cases and cases that represent a significant vulnerability to the Medicare program and have a significant provider impact (e.g., providers whose review represents high dollars or high volume). This process must assure that the appropriate professional personnel are available to review such cases. The intermediary may wish to determine an internal claim processing error rate. The QI program must assure that the intermediary has good management practices. One way that intermediaries can ensure good management procedures is to become ISO

9000 certified[1] or to undergo a third party validation process. The intermediary must consider the appeals reversal rate when making decisions concerning the medical review process. The medical review manager should work to resolve conflicts between the appeals and medical review areas. The medical review manager should communicate with other Medicare contractors concerning best practices of the medical review process. The medical review manager must submit a report of findings for the QI program. This report must be submitted 30 days after the close of the second and fourth quarters. This report must be entitled "Medical Review Quality Improvement Program" and include, at a minimum, the results of inter-reviewer reliability studies, a description of the medical review process, a synopsis of management practices and any actions taken as a result of the intermediary's findings. The report must be submitted to the Regional Office and copied to the Central Office at MROperations@cms.hhs.gov.

Communication with Beneficiaries and Providers

Beneficiaries and providers are our customers. Therefore, medical review staff is expected to provide the appropriate level of customer service to both providers and beneficiaries. Medical review personnel must communicate effectively with providers and beneficiaries concerning the determinations made during the medical review process. This level of communication may require in-person, telephone or written communications in order for the customer to fully understand the medical review processes and procedures, as well as medical review determinations. Medical review personnel must be fair, responsive, and courteous when addressing all inquiries. Effective communication with the beneficiaries and providers we serve is critical. In addition, MR personnel should provide adequate feedback to customer service personnel so that they can interpret and explain medical review decisions when questioned by the beneficiary or the provider. Conversely, MR personnel should obtain feedback from customer service representatives regarding beneficiary and provider comments about medical review policies, processes, and decisions.

MIP-PET in Medical Review

MIP-PET is remedial and concentrates primarily on providing feedback to providers based on data analysis and medical review results. MIP-PET activities include one-on-one feedback for provider specific errors; community-wide feedback for widespread errors; and general information about Program Integrity activities. Usually this feedback can be provided best by the Program Integrity component most familiar with the work. For instance, medical review personnel would be able to provide the most accurate feedback concerning issues related to medical review.

For FY 2001, intermediaries should **not** include costs associated with medical review related to provider outreach or education activities in their MR request. Although MIP-PET activities are an integral part of the MR program, these costs must be reported in the Medicare Integrity Program Provider Education and Training (MIP PET) activity code.

Internal Coordination

Interaction and coordination among the intermediary's appeals unit, fraud unit, medical review unit, provider enrollment unit, and provider relations unit is essential in determining the appropriate actions to be taken to resolve Program Integrity issues. The goal of this coordinated, inter-disciplinary effort is for all parties to work as an informed team to arrive at an agreed upon resolution of outstanding Program Integrity concerns/issues. Intermediaries must coordinate, interact, and share information through monthly meetings with internal contractor staff from the fraud, medical review, provider enrollment, and provider relations units. The MR manager must have readily available copies of the minutes of these inter-disciplinary meetings for Regional Office and Central Office review.

Workload Information and Documentation

[1]For more information concerning ISO 9000 certification, on the World Wide Web go to www.ASQ.org, or call 1-800-248-1946.

For HCFA review purposes, the intermediary must assure the presence of workload information and documentation at each site for those intermediaries that retain multiple medical review processing sites. At a minimum, this information must include workload information captured by the Interim Expenditure Report (IER). Additionally, the intermediary must maintain collective workload information at each site. Intermediaries that operate in multiple sites may be requested to provide this information on an on-going basis. The Regional and Central Office may request workload information separately for each field office.

Focus on Program Vulnerabilities

The intermediary must make every effort to increase the effectiveness of medical review payment safeguard activities. The intermediary should focus reviews to those areas of program vulnerability identified through data analysis and by the Office of the Inspector General through their reports and the CFO Audits. HCFA will inform the intermediary on a semi-annual basis of these reports and other areas of program vulnerabilities identified at the national level.

Random Review and the Comprehensive Error Rate Testing (CERT) Program

As previously stated Medicare's program integrity goal is to pay claims right. To assure that only covered claims are paid, the FY 2001 BPR maximizes the amount of random and data driven prepayment review. Specifically, each intermediary should develop and implement a random prepayment review process in addition to their data driven medical review process. Random review places the provider community on notice that every claim has the potential to be reviewed. However, the implementation of the Comprehensive Error Rate Testing (CERT) program replaces the requirement for random review. Therefore, once the intermediary has implemented the CERT program it must cease its random review process.

Progressive Corrective Actions

Contractors are to continue to analyze data, complaints, and other sources of information to focus their medical review efforts. However, once the information is analyzed, non-compliance with Medicare rules and regulations should be prioritized depending on the severity of the non-compliance and the magnitude of risk to the Medicare program. Employ a variety of MR tools depending upon the severity of the billing error. These tools range from provider feedback and education to the review of a statistically valid random sample of claims for the purpose of extrapolating an overpayment. Analysis of a small sample of claims, i.e., a probe review, will suffice to determine if a more extensive review must be undertaken. However, the intermediary must provide feedback to the provider prior to proceeding with additional corrective action(s). Provider feedback is critical in eliminating billing errors to the Medicare program. Provider feedback is not required in instances of suspected fraud when the provider is referred to your fraud unit. (Note: Provider feedback and education is considered a MIP PET activity.)

Medical Review Activities

The intermediary's medical review strategy must ensure that the appropriate level of review is performed. Ensure that the least burdensome, most efficient level of review is utilized. For example, do not conduct routine reviews when the system is capable of addressing the review in an automated fashion. Likewise, do not perform complex reviews when the medical review determination can be made at the routine review level. Intermediaries must exercise efficiency in meeting workload goals. The intermediary must ensure that prepayment review activities are given preference over postpayment review activities. Therefore, allocations for postpay review must never exceed allocations for prepay review. Prepay medical review activities should begin on the first day of FY 2001 and continue throughout the year. In order to assure that an intermediary's workload is stable throughout the year, intermediaries are expected to perform all types of prepayment and postpayment review each and every month. The MR manager must submit a report outlining their annual MR strategy to the Regional Office and copy the Central Office at MROperations@cms.hhs.gov by close of business November 1, 2000. This report should include intended areas for focusing the carriers medical review resources and the types of review anticipated. Additionally, the intermediary's strategy must include the review of claims resulting from the implementation of prospective payment systems for skilled nursing facilities, outpatient services, and home health services.

PPS Reporting Requirements

The medical review manager may be required to submit a quarterly report containing information related to Skilled Nursing Facility PPS, Outpatient PPS, and Home Health PPS.

Home Health Prospective Payment System Review

Regional Home Health Intermediaries (RHHIs) must exceed the complex review workload percentages established under the complex manual review section. RHHIs should anticipate extensive monitoring of Home Health PPS. At a minimum, intermediaries will maintain their current level of effort without diminution when converting to the home health PPS medical review strategy. The intermediary must be prepared to perform home health PPS medical review immediately upon implementation of the home health PPS. They should be prepared to monitor and provide quarterly reports to HCFA related to Home Health PPS medical review findings.

Skilled Nursing Facility Prospective Payment System Review

Whenever possible the intermediary's budget should reflect the migration of SNF PPS review to prepayment review as opposed to the current postpayment review processes. Intermediaries should consider prepayment review taking into consideration provider and beneficiary impact. Intermediaries that cannot perform prepayment review may continue their postpayment review process. SNF PPS workload must consist of 1-3% of SNF PPS total claims volume processed. Prepayment funding must be included in CAFM II line 21003 and postpayment funding must be included in CAFM II line 21004.

Prepayment Claim Review Activities

Prepayment review is divided into three distinct types of reviews. These three types are defined as:

- **Automated Review**
  This review does not involve any human intervention whatsoever. It occurs when a claim/line passes through the intermediary's medical review system edits or any adjunct system containing medical review edits **AND** is denied in whole or in part because the service(s) is not covered (including not reasonable and necessary).

- **Routine Manual Review**
  Routine review requires hands on review of the claim and/or any attachment submitted by the provider, excluding the evaluation of medical records for the purpose of preventing payments of non-covered or incorrectly coded services. This review would include any other existing documentation internal to the intermediary, such as the claims history file or policy documentation. Experienced and specially trained staff should perform these reviews.

- **Complex Manual Review**
  Complex review goes beyond the routine manual review process to include the evaluation of medical records or any other documentation for the purpose of preventing payments of non-covered or incorrectly coded services. Professionals must perform complex manual reviews, i.e., at a minimum, by LPNs.

Automated Review (Activity Code 21001)

In FY 2001, MR units are expected to make every effort to increase their amount of automated medical review. For example, wherever possible, each intermediary must implement National Coverage Policies or Local Medical Review Policies (LMRP) through systems edits. When services are excluded by statute or National Coverage Policy, or when National Coverage Policies or LMRP states that a service is never covered, systems edits must be developed to automatically deny these services. Intermediaries may consider the use of supplemental edit software as an adjunct to the standard system in order to implement automated prepayment review.

Report the costs associated with automated review including personnel to install and activate supplemental edit software in Activity Code 21001. In the workload section of the CAFMII in Activity Code 21001, intermediaries should report the number of claims denied in whole or in part in both Workload 1 and Workload 2 (i.e., the same number should appear in Workload 1 and in Workload 2). To the extent the intermediary can report lines denied, they should be reported in Workload 3.

Routine Manual Reviews (Activity Code 21002)

In FY 2001, there will be no workload goal for routine manual reviews. Instead, the intermediary shall implement the most efficient medical review standard. Only in those instances where reviews cannot be automated shall the intermediary conduct routine review.

For claims that suspend for routine manual review, each intermediary shall review the claims using the intermediaries internal review guidelines. To the extent possible, these reviews should focus on those areas identified as program vulnerabilities. Program vulnerabilities can be identified by HCFA or by the intermediary. Experienced and specially trained staff should perform these reviews.

Report all costs associated with routine manual reviews in Activity Code 21002. In the workload section of the CAFMII in Activity Code 21002, report the number of claims reviewed in Workload 1. Intermediaries should report number of claims denied in whole or in part in Workload 2. To the extent the intermediary can report lines denied, they should report this number in Workload 3.

Complex Manual Reviews (Activity Code 21003)

The purpose of complex manual review is to determine if the underlying medical documentation supports the services billed. The intermediary's workload for complex manual reviews is established as a goal to be obtained over the next two years. Intermediaries that have already met or exceeded this goal must, at a minimum, maintain their current workload. The workload goal for focused complex manual reviews is 1.08% of total claims volume processed per month excluding inpatient hospital. Intermediaries shall perform complex manual reviews directed toward identified areas of program vulnerabilities. Program vulnerabilities can be identified by HCFA or by the intermediary.

In addition to the intermediary's focused complex review workload of 1.08%, the intermediary must perform random complex manual reviews on 0.01% of the total claims volume processed per month excluding inpatient hospital claims. The intermediary must perform random reviews every month until the implementation of the Comprehensive Error Rate Testing (CERT) program. The CERT program will replace the requirement for random reviews. Random review is defined as every otherwise payable claim with submitted charges above $10 in the total universe of all claims excluding inpatient hospital claims, has the exact same probability of being selected for review. If the intermediary cannot perform random review as defined but can perform random review on the vast majority of claims, the intermediary must submit their plan to perform modified random review to the regional office for approval. If the intermediary is unable to perform random review or modified random review as approved by the regional office, the intermediary must perform an equal percentage (0.01% of the total claims volume processed per month excluding inpatient hospital claims) of random postpay review on a timely basis, i.e., the postpay review must be completed within three months once the claim is selected for review. Random complex manual reviews should be considered a part of the intermediaries normal prepayment review process and workload. Intermediaries should take steps to increase the receipt of requested documentation. Professionals must perform complex manual reviews, i.e., at a minimum, LPNs. Physician input must be provided when necessary to make accurate review decisions.

Report all costs associated with complex reviews in Activity Code 21003. In the workload section of the CAFMII, in Activity Code 21003 report the number of claims reviewed in Workload 1. Intermediaries should report the number of claims denied in whole or in part in Workload 2. To the extent the intermediary can report lines denied, they should report this number Workload 3.

Third Party Liability or Demand Bills (Activity Code 21010)

In FY 2001, the intermediary must report only the workload and costs associated with the medical review of third party liability claims and the workload and costs associated with the medical review of demand bills. (The intermediary may refer to Medicare Intermediary Manual Section 3900.1 B & C for more information concerning demand bills.) Funding for claims processing and the appeals for third party liability and demand bills must be funded through program management.

Report the costs associated with the medical review of third party liability and the medical review of demand bills in Activity Code 21010. In the workload section of the CAFMII, in Activity Code 21010 report the total number of claims reviewed, i.e., third party liability claims plus claims for demand bills, in Workload 1. Report the number of claims denied in whole or in part in Workload 2. To the extent the intermediary can report claims associated with the "Statement of Intent to Bill Medicare", these claims should be reported in Workload 3.

Postpayment Claim Review Activities (Activity Codes 21004, 21005, 21006)

In FY 2001, the workload for postpayment review is established as a goal to be obtained over the next two years. Intermediaries that have already met or exceeded this goal must, at a minimum, maintain their current workload. The workload goal for postpayment review is 0.04% of the total claims volume processed per month excluding inpatient hospital and ambulatory surgical center claims. These reviews can be conducted either onsite or in-house. For claims that suspend for routine manual postpay review, each intermediary shall review the claims using the intermediaries internal review guidelines. Experienced and specially trained staff should perform these reviews. Professionals must perform complex manual postpay reviews, i.e., at a minimum, LPNs. Physician input must be provided when necessary to make accurate review decisions.

Report all costs associated with the postpayment medical review of claims, e.g., sampling design and execution; claims examination, reviewing medical records and associated documentation; assessing overpayments; and contacting providers to notify them of overpayment assessment decisions.

Report all costs associated with postpayment claims review, on-site postpayment claims review, and in-house postpayment claims review in Activity Codes 21004, 21005, and 21006, respectively. In the workload section of each CAFM II code, report the total number of claims reviewed on a postpayment basis in Workload 1, report the total number of claims denied in whole or in part in Workload 2. Intermediaries must keep a record of their postpayment review workload including number of claims denied in total or in part, the total number of CMRs completed during the fiscal year, the amount of overpayments identified, and the amount of actual recovery.

Data Analysis Activities (Activity Code 21007)

Each intermediary must use comprehensive data analysis software or hardware tools. Intermediaries who are not currently utilizing data analysis tools may consider using Limited On-Line Access Plus (LOLA+) for their data analysis activities. Intermediaries that want to begin using LOLA + must contact Jstewart@cms.hhs.gov . Each intermediary should conduct sophisticated data analysis to identify potential errors. This data analysis effort must be coordinated with the fraud unit to ensure that corrective actions, such as medical record reviews, initiated by either the MR unit or the Fraud Unit do not overlap or unduly burden the provider.

In addition to the activities described in the Program Integrity Manual intermediaries must accommodate the following data analysis activities:

- Refine data analysis approaches, methods, and software to improve the identification of potential errors. Resources will guide your review selection process with those potential errors demonstrating the greatest risk to the Medicare program receiving priority. Once data analysis has revealed a potential error, the intermediary must determine if the potential error represents a widespread problem or a concentrated problem, as this will guide the intermediary's selection of appropriate corrective actions.

- Identify problems that might require the development of LMRP. LMRPs must be developed for those items or services that pose a high risk to the Trust Fund (i.e., high dollar, high volume). The intermediary's data analysis will assist in prioritizing which items/services require an LMRP and which can be managed through individual claims determination.

Report all costs associated with data analysis activities in CAFMII Activity code 21007 **except** for data analysis associated with law enforcement support. Data analysis costs associated with law enforcement support should be reported using CAFMII Activity code 21009 for MR law enforcement support or 23006 for Benefit Integrity law enforcement support. There is no final claims workload to be reported for this activity.

Policy Development Activities (Activity Code 21008)

The Contractor Medical Director's primary responsibility is the development of Local Medical Review Policies. Report all costs associated with the development and implementation of local medical review policies. At a minimum, intermediaries must perform the following activities:

- In general, Local Medical Review Policies (LMRP) must be developed for those services that demonstrate a significant risk to the Medicare trust fund. These services include either identified or potentially high dollar and/or high volume services. Special consideration should be made to the development of LMRP to assure beneficiary access to care. CMDs should continue to make individual claim determinations for those services that are not addressed by an LMRP.

- Coverage determinations must never be published in the contractor bulletin unless those determinations were developed through the local medical review policy or national coverage policy development process.

- Assure that the LMRP development process, including the template development process, remains open to the public. Template policy development must be receptive to concerns of the general public. Intermediaries must include public meetings to discuss draft LMRPs.

- Collaborate on the development of LMRP through clinical workgroups.

- Conduct training sessions to educate medical review staff about LMRPs and internal medical review guidelines.

- Conduct training sessions to educate customer service and provider representatives about LMRPs and internal medical review guidelines.

- Employ at least one full time CMD. The Regional Office may make exceptions for those fiscal intermediaries with extremely low claims volume.

- Post clearly marked draft and final Local Medical Review Policies on your internet website in accordance with the guidelines stated in the program management provider education and training BPR. The website must be updated as policies are developed or finalized. Implement the capability to accept electronic comments related to these policies by January 1, 2001. The MR manager must submit the internet address of the website to the Regional Office and copy the Central Office at MROperations@cms.hhs.gov.

- The intermediary must support the Local Medical Review Policy Analysis Contractor (Kathpal Technologies, Inc.) in their efforts. At a minimum, continue to send revised final and final LMRP to ContractorPolicy@cms.hhs.gov.

Report all costs associated with LMRP activity in CAFMII Activity code 21008. Report the number of policies that required notice and comment and became effective in Workload 2. Report the number of policies that were presented for notice and comment in Workload column 3.

Law Enforcement Activities (Activity Code 21009)

Intermediaries may receive requests from the OIG, or other Federal agencies, State, or local law enforcement for data and documents related to potential or ongoing audits, civil or criminal health care fraud investigations. The intermediary must follow the Program Integrity Manual when addressing these requests.

For work done to support law enforcement, report all medical review and related data analysis costs in CAFMII Activity code 21009. Report number of claims reviewed in workload Column 1. Report number of medical review data analysis requests in workload Column 2. Report the number of law enforcement requests in workload Column 3.

Other Activities

Intermediaries must work with any and all Program Safeguard Contractors (PSC), or other entities that contract with HCFA.

SUMMARY OF MEDICAL REVIEW CAFM II ACTIVITY CODE DEFINITIONS FOR INTERIM EXPENDITURE REPORTS

Activity Code	Review Type	Workload 1	Workload 2	Workload 3
21001	Automated Review	Claim denials in whole or in part	Claim denials in whole or in part	Line items denied in whole or in part
21002	Routine Manual	Claims reviewed	Claims denied in whole or in part	Line items denied in whole or in part
21003	Complex Manual	Claims reviewed	Claims denied in whole or in part	Line items denied in whole or in part
21004	Postpay Reviews	Claims reviewed	Claims denied in whole or in part	N/A
21005	On-Site Postpay Reviews	Claims reviewed	Claims denied in whole or in part	N/A
21006	In-House Postpay Reviews	Claims reviewed	Claims denied in whole or in part	N/A
21007	Data Analysis (Costs only)	N/A	N/A	N/A
21008	Policy Development	N/A	Number of policies Requiring notice and comment that Became effective during the month	Number of policies presented for notice and comment during the month
21009	Law Enforcement	Claims reviewed	Number of MR Data Analysis requests	Number of law enforcement requests
21010	Third Party Liability and Demand Bills	Claims reviewed	Claims denied in whole or in part	Claims associated with the "Statement Of Intent to Bill Medicare"

SUPPORTING DOCUMENTATION FOR FY 2001 BPR REQUESTS

Any increase in funding from FY 2000 base activities, as required in the FY 2001 BPR, must be accompanied by the following information in order for the appropriate funding decisions to be made. Include the identification of any new BPR activities that may cause increase in funding from the FY 2000 base activities.

FY 2001 BUDGET AND PERFORMANCE REQUIREMENTS
MEDICARE INTEGRITY PROGRAM

Medicare Secondary Payer (Intermediary)

THESE REQUIREMENTS STAND ALONE AND SUPERSEDE PRIOR YEARS BPRS

There has been a change in the contractor community during this past year. That change, which includes the establishment of a Coordination of Benefits (COB) Contractor to handle all front end MSP activities, will cause a change in the work flow for MSP contractor pre-pay and post-pay activities. Additionally, intermediaries and carriers no longer have any dollar tolerance (that is, there is a zero tolerance amount) for MSP development and have no recovery tolerances except for Group Health Plan (GHP) recoveries. Contractors are reminded that there is no backend tolerance for GHP recoveries (that is, once a demand is issued, the fact that the amount of the debt falls below $1,000 due to partial payment or some other reason does not permit the case to be closed. The resulting changes are included in the pre-pay and post-pay BPRs set forth below.

These BPRs presume funding for ongoing activities. In general, these MSP activities are described in the following sections of the Medicare Intermediary Manual (MIM)/Medicare Carrier Manual (MCM) or the successor sections and in the specific instructions contained in the communications identified below. Where the MCM has been updated and the MIM has not, intermediaries should follow the policy in the updated manual (recognizing that some of the operational terms may not translate exactly for intermediaries).

Working Aged	MIM 3682, 3491 MCM 3336
Disabled	MIM 3492, 3682 MCM 3337
Workers= Compensation	MIM 3682, 3407-17 MCM 3330
Liability and No-fault	MIM 3682, 3418 MCM 3340
ESRD	MIM 3682, 3687, 3490 MCM 3335
MSP Standard Software	MIM 3697
MSP Common Working File	MIM 3694, 3696
Recovery of Mistaken Payments	MIM 3491
MSP Savings Reports	MIM 3899
Billings for Hospitals	MIM 3693

Guidance you received from your regional office based on our August 28, 1996 memo titled AUse of Employer Demand Letters to Protect HCFA=s Legal Rights in IRS/SSA/HCFA Data Match Recovery Cases≅ from Lisa Vriezen to All Associate Regional Administrators for Medicare (AFirst≅ August 28, 1996 memo).

Guidance you received from your regional office based on our August 28, 1996 memo titled AClarification of FY 1997 Budget and Performance Requirements (BPRs) Concerning Medicare Secondary Payer MSP Recovery Periods≅ from Lisa Vriezen to All Associate Regional Administrators for Medicare (ASecond≅ August 28, 1996 Memo).

Guidance you received from your regional office based on our November 25, 1996 memo titled, ARecent Court Orders in Health Insurance Association of America v. Shalala and Revised Operating Instructions≅ from Lisa Vriezen to All Associate Regional Administrators for Medicare. **(This memo includes front-end tolerances for GHP recoveries.)**

Guidance you received from your regional office based on our December 19, 1996 memo titled, AResponses to Contractor and Regional Office Questions Generated Regarding Implementation of November 25, 1996 Revised Operating Instructions Issued Subsequent to Court Orders in Health Insurance Association of America v. Shalala≅ from Lisa Vriezen to All Associate Regional Administrators for Medicare.

Guidance you received from your regional office based on our August 29, 1997 memo titled, AMSP: Group Health Plan Recovery Demand Letter to Employer Language≅ from Lisa Vriezen to All Associate Regional Administrators for Medicare.

Program Memorandum AB 98-6 dated March 27, 1998 (reissued as AB 98-68 dated November 1998) entitled AIdentifying Employer in Other than Data Match Group Health Plans - Medicare Secondary Payer Recovery Situations.≅

MSP PRE-PAY ACTIVITIES - (ACTIVITY CODES 22001and 22005)

Note: Program Memorandum (CR #1163, AB-00-36) provides further detail on the changes set forth below (including details on any record layouts) was issued May 1, 2000 for implementation on October1, 2000 and is currently being revised for implementation on January 1, 2001.

Effective 1/1/2001, FY 2001 BPRs reflect major work changes from the FY 2000 BPRs, due to the transfer of pre-pay development functions to the COB contractor. With the establishment of the COB contractor, intermediaries will no longer perform First Claim Development (FCD) when the intermediary receives a first claim for a beneficiary. Intermediaries will no longer perform Trauma Code Development (TCD) when a claim is submitted with a diagnosis code that indicates the possibility of other coverage, primary to Medicare, for an accident/injury or illness.

Two of the activities, “updating HCFA records timely and electronic requests and referrals for COB contractor update of HCFA records” and “ electronic requests and referrals to the COB contractor for MSP record deletions (and/or further investigation, if appropriate),” set forth intermediary authority as of 1/1/2001 regarding adding, updating, and deleting MSP auxiliary records on the Common Working File (CWF). These are new functional parameters for intermediaries as a result of the COB contractor.

The following MSP pre-pay activities are listed in order of priority. This order of priority is effective until 12/31/2000. ALL OF THESE ACTIVITIES ARE MANDATORY.

1. Update HCFA records timely.
2. Develop the first claim submitted on behalf or by the beneficiary which is identified by the CWF "Z" trailer.
3. MSP Hospital audits and Reviews
4. Special Projects (includes litigation support).

1. Updating HCFA Records Timely (Activity Code 22001)

Upon receipt of information that may affect Medicare's status as a primary or secondary payer (i.e. correspondence from attorneys, beneficiaries, third party payers, or another insurer's EOB) evaluate the information and determine its effects on Medicare payment status. If warranted, update CWF within 10 calendar days from completion of evaluation or within 30 calendar days from receipt of the information from any informational source, whichever is less.

2. First Claim Development (FCD) (Activity Code 22001)

Develop the first claim, submitted by or on behalf of the beneficiary, which has been identified by a "Z" trailer in CWF. The FCD letter should be sent to the provider of service. No follow-up mailings should be initiated based on the absence of a provider response. Negative responses should not be entered into CWF.

3. Trauma Code Development (Activity Code 22001)

For liability, no-fault, and workers' compensation, intermediaries will initiate development on all trauma codes as outlined within the various sections of the MIM.
Development is not required on each bill received which is representative of the same beneficiary occurrence. TCD should continue via the HCFA L-365, Report to Medicare of Automobile or Liability Insurance Coverage, or an alternative development letter or form that has been approved for use by the intermediaries' RO.

4. MSP Hospital Audits and Reviews (Activity Code 22005)

This activity will remain the same as number 4 in the prepay section below.

5. Special Projects (Activity Code 22001)

Implement special MSP projects pursuant to specific instructions that HCFA may issue.

The following MSP pre-pay activities are listed in order of priority. This order of priority is effective 1/1/2001. ALL OF THESE ACTIVITIES ARE MANDATORY.

1. Updating HCFA records timely and electronic requests and referrals for COB contractor update of HCFA records.
2. Electronic requests and referrals to the COB contractor for first claim development issues.
3. Electronic requests and referrals to the COB contractor for liability, no-fault, and workers' compensation cases.
4. MSP hospital audits and reviews.
5. Electronic requests and referrals to the COB contractor for MSP record deletions (and/or for further investigation, if appropriate).

1. <u>Updating HCFA Records Timely and Electronic Requests and Referrals for COB Contractor Update of HCFA Records (Activity Code 22001)</u>

Effective 1/1/2001, intermediaries should discontinue updating the CWF, with the following exceptions:

A. When the intermediary receives a phone call or correspondence from an attorney, beneficiary, third party payer, provider, another insurer's EOB or other source that establishes, -- exclusive of any further required development or investigation -- that MSP no longer applies (e.g., beneficiary or spouse has retired), the intermediary should post a termination date to the MSP auxiliary record. Update CWF within the lesser of: 1) 10 calendar days from completion of the evaluation, or 2) 30 calendar days of the mailroom date stamped receipt/date of phone call, as applicable.

B. When the intermediary receives a secondary claim that includes sufficient data (e.g., EOB) to warrant adding an MSP auxiliary record, the intermediary should add the MSP occurrence using an "I" validity indicator.

C. When the intermediary determines that an unsolicited refund is MSP based, and the referral document contains sufficient information to create an "I" record without further development; the intermediary should add the MSP occurrence using an "I" validity indicator. Update CWF within the lesser of: 1) 10 calendar days from completion of the evaluation, or 2) 30 calendar days of the mailroom date stamped receipt/date of phone call, as applicable.

D. You receive a claim for conditional payment and the claims contains sufficient information to create an "I" record without further development. You must add the MSP occurrence using an "I" validity indicator. Update CWF within 10 calendar days from completion of the evaluation.

The above four instances are the <u>only</u> instances in which the intermediary has the authority to update the CWF. For all other instances, the intermediary must submit an electronic referral to the COB contractor, using the COB contractor Electronic Correspondence Referral System. Depending on the situation, these electronic referrals will take the form of either a CWF assistance request or an MSP inquiry.

For CWF assistance requests or MSP inquiry referrals, information should be electronically forwarded within 20 calendar days of mailroom date stamped receipt, or date of phone call. If requested, intermediaries must fax to the COB contractor within 5 business days of request a copy of any correspondence or substantiating information related to the electronic referrals.

2. <u>Electronic Requests and Referrals to the COB Contractor for First Claim Development (FCD) Issues (Activity Code 22001)</u>

Effective 1/1/2001, intermediaries will no longer be responsible for first claim development. The first claim submitted to Medicare by or on behalf of a beneficiary will be developed by the COB contractor. FCD letters that are received by intermediaries on or after 1/1/2001 should be forwarded to the COB contractor within 20 calendar days of mailroom date stamped receipt. Any information the intermediary plans to transmit to the MSP auxiliary file for FCD letters received prior to 1/1/2001 must be transmitted to CWF by 1/1/2001. Any requests for changes after that date must be submitted through the COB Contractor Electronic Correspondence Referral System. Intermediaries must use the electronic CWF assistance request.

3. Electronic Requests and Referrals to the COB Contractor for Liability, No-Fault, and Workers'Compensation Cases (Activity Code 22001)

Effective 1/1/2001, intermediaries will no longer be responsible for trauma code development (TCD), through the use of the L-365 or any other TCD tool. Claims that are received which contain an ICD-9 code as listed within the MIM will be developed by the COB contractor. The following additional procedures apply:

A. TCD letters that are received by Medicare intermediaries on or after 1/1/2001 should be forwarded to the COB contractor within 20 calendar days of mailroom date stamped receipt.

B. When an intermediary receives information from an attorney, beneficiary, provider, or liability carrier or other source which establishes, exclusive of any further required development or investigation, that MSP no longer applies (e.g., personal injury protection exhausted), the intermediary should post a termination date to the MSP auxiliary record. Update CWF within the lesser of: 1) 10 calendar days from completion of the evaluation, or 2) 30 calendar days of the mailroom date stamped receipt/date of phone call, as applicable.

C. The intermediary must submit to the COB contractor any information that may necessitate a change/update to the auxiliary record, exclusive of a termination date, using the COB Contractor Electronic Correspondence Referral System. These electronic referrals should constitute either a CWF assistance request or an
MSP inquiry. Information should be electronically forwarded within 20 calendar days of the mailroom date stamped receipt or phone call date. If requested, intermediaries must fax to the COB contractor within 5 business days of request, a copy of any correspondence or substantiating information related to the electronic referrals.

4. MSP Hospital Audits (Activity Code 22005)

Intermediaries must conduct annual hospital audits to review hospital admission and billing office procedures. MIM Section 3696, Review Protocol for Medicare Secondary Payer, contains the review instructions that govern the processes and procedures for conducting hospital audits. Summary results of the hospital reviews are to be sent to the appropriate Regional Office (RO) no later than 30 calendar days from the date of onsite completion of the review. The date of completion of onsite review must be documented on Exhibit 1 (found at MIM 3696) - Assessment of Medicare Secondary Payer Hospital Review, under the lead heading, Contractor Name and Number.

5. Electronic Requests and Referrals to the COB Contractor for MSP Record Deletions (and/or Further Investigation, If Appropriate) (Activity Code 22001)

When an intermediary discovers, through the receipt of documentation from a beneficiary, provider, group health plan, attorney, or other source, that there is an erroneous MSP record on CWF, the intermediary should request that the record be deleted using the COB Contractor Electronic Correspondence Referral System. Intermediaries must use the electronic CWF assistance request to request a deletion. Information should be electronically forwarded within 20 calendar days of mailroom date stamped receipt. If requested,

intermediaries must fax within 5 business days of request, a copy of any correspondence or substantiating information related to the electronic referrals.

Workload

The Prepayment workload (Workload 1 in CAFMII) for Activity Code 22001 is the cumulative workload reported on Line 1, Total Column of the HCFA-1563.

The Hospital Audit workload (Workload 1 in CAFMII) for Activity Code 22005 is the cumulative number of MSP hospital audits performed.

MSP POST-PAY ACTIVITIES (ACTIVITY CODES 22002 and 22003)

The following MSP post-pay activities are listed in order of priority. This order of priority is effective until 12/31/2000. ALL OF THESE ACTIVITIES ARE MANDATORY.

Funding should be requested for the following activities, which are listed in priority order:

1. Pursue recovery of identified primary mistaken payments.
2. MSP adjustment process.
3. Special projects (includes litigation support).

1. **Pursue recovery of identified primary mistaken payments.**

A. **Liability, No-Fault, Workers= Compensation - Code 22002**

Contractors are reminded that they must develop further and pursue recovery whenever they receive information that a beneficiary, provider, physician, or other supplier is pursuing a claim against workers= compensation insurance, no-fault insurance or liability insurance. In recovery situations, contractors must cooperate with the lead contractor (if they are not the lead contractor), in all instances, regardless of the amount the non-lead contractor has at issue.

1) If the contractor has specific information from any source that workers= compensation insurance or no-fault insurance has acknowledged primary payment responsibility or that liability insurance has either made payment or acknowledged liability with respect to services that may have been provided to a Medicare beneficiary, the contractor must develop for any additional needed information and pursue recovery of Medicare=s repayment claim in all cases. Sources that may provide such information include providers, physicians or other suppliers, beneficiaries, attorneys, insurers, etc. The contractor must also develop if it receives a general inquiry about services provided to a Medicare beneficiary from workers= compensation insurance, no-fault insurance or liability insurances or an attorney representing one or more of these insurers or a specific beneficiary. There are no development or recovery tolerances in these instances.

2) If the contractor receives information from a beneficiary, attorney, insurance company, provider, supplier, or any other entity that a beneficiary---or some other entity acting on behalf of the beneficiary under a subrogation right---is/will pursuing a claim against a tort-feasor and/or his/her liability insurance, workers= compensation insurance or, no-fault insurance (in a L-365 response, letter, phone call, e-mail, etc), the contractor is obligated to develop further with the appropriate parties and pursue recovery. There are no development or recovery tolerances in these instances.

NOTE: The submission of an L-365 with a Anegative≅ response does not negate the requirement for development when subsequent information is received from another source which indicates pursuit of a claim.

3) If the contractor receives information from any source that workers= compensation, no-fault or liability insurance may have primary payment responsibility for services provided to a specific Medicare beneficiary, the contractor must develop for more information (manually or otherwise) and pursue recovery when either of the following conditions or circumstances are present:

a. A claim form indicates that services were work or accident related and the amount of the Medicare payment for these services is $500.00 or more even if there is no procedure codes indicating trauma.

The contractor must develop with the provider/supplier that submitted the claim or the beneficiary, as appropriate, and pursue recovery of any identified Medicare repayment claim.

If the development reveals that a claim is being pursued against workers= compensation insurance, no-fault insurance, or liability insurance (or tort-feasor), the contractor must follow the rules in 1.a.2. above.

b. A claim form indicates that services were work or accident related and the amount of the Medicare primary payment for these services is less than $500.00.

The contractor must: (1) search its claims history and CWF claims history with respect to claims processed by other contractors and determine if there are other claims that may be related to the claim linked to work or accident related services; (2) add the Medicare payment amounts on the claims identified in the preceding step; (3) if the total Medicare payment amount computed in the preceding step is $500 or more, develop with the appropriate entities.

If the development reveals that a claim is being pursued against workers= compensation insurance, no-fault insurance, or liability insurance (or tort-feasor), the contractor must follow the rules in 1.a.2. above.

Note: Contractors may lower the development tolerance (in item 3.b.) is cost-effective.

B. **Non-Data Match Group Health Plan - Code 22002**

1) If a group health plan specifically acknowledges that Medicare made a mistaken primary payment for a specific service and specifically acknowledges that it should have or did make a primary payment, recover the Medicare primary payment from the group health plan or the appropriate party (beneficiary, provider or supplier).

2) In the absence of such specific information, a contractor is obligated to search history if it receives information on a claim form, in response to a development letter, or otherwise that an MSP situation may exist, with respect to services to an identified beneficiary provided on or after August 5, 1997. Due to the enactment of the Balanced Budget Act of 1997 (BBA 1997), for all services on or after August 5, 1997, Medicare has a minimum of 3 years to initiate recovery without regard to a plan=s timely filing requirements.

If the history search identifies potential mistaken primary payments that equal or exceed $1000, the contractor is obligated to seek recovery by sending a demand letter to the employer that sponsors or contributes to the group health plan. Carriers are not to recover from the supplier, unless the supplier has received a duplicate primary payment from the group health plan and Medicare.

See the regional office instructions based on the Lisa Vriezen memos dated August 28, 1996, November 25, 1996, December 15, 1996, August 29, 1997, and PM AB 98-6 (reissued as AB 98-68 dated November 1998.)

C. **Recoveries from IRS/SSA Data Match - Code 22003**

See the regional offices instructions based on the Lisa Vriezen memos dated November 25, 1996 and the August 29, 1997 but make the following changes:

1) Change the date from January 1, 1997 to August 5, 1997 wherever the January 1, 1997 date appears. Due to the enactment of the Balanced Budget Act of 1997 (BBA 1997), for all services on or after August 5, 1997, Medicare has a minimum of 3 years to initiate recovery without regard to a plan=s timely filing requirements.

2) Amend the next to last sentence in item 2(a)(ii) on page 2 of the November 25, 1996 memo to read, ASend an initial demand letter within 60 days of receipt of a Data Match cycle tape from HCFA or its agent, to the employer. Carriers are not to recover from the physician or other supplier, unless the physician or other supplier has received a duplicate primary payment from the group health plan and Medicare.

The contractor is to update MPARTS within 10 calendar days from completion of evaluation or within 30 calendar days from receipt of information, whichever is less.

2. **Special Projects (MSP Prepay and Postpay activities 22001 through 22006)**

Implement special MSP projects pursuant to specific instructions that HCFA may issue.

MSP POST-PAY ACTIVITIES (ACTIVITY CODES 22002 and 22003)

The following MSP post-pay activities are listed in order of priority. This order of priority is effective 1/1/2001. ALL OF THESE ACTIVITIES ARE MANDATORY.

1. Pursue recovery of identified primary mistaken payments, including recoverable conditional payments.
2. MPaRTS updates.
3. Special projects (includes litigation support).

1. Pursue Recovery of Identified Mistaken Primary Payments, Including Recoverable Conditional Payments (Activity Codes 22002 and 22003)

A. Notices/Inquiries –

1) As stated in the MSP pre-pay BPRs, effective 01/1/2001, intermediaries will only have authority to update CWF in a limited number of situations. It is important that intermediaries understand what this means with respect to the notices or inquiries they have routinely received in the past and which they used as the basis for further development or other action for MSP recoveries.

2) For written correspondence and telephone calls:

a) If it is clear that the correspondence is an initial contact for a potential recovery case,

(i) for correspondence, the inquiry/correspondence should be transferred to the COB contractor using the COB contractor Electronic Correspondence Referral System.

(ii) for telephone calls, the call must be transferred to the COB contractor at the time of the call or the information must be submitted to the COB contractor using the COB contractor Electronic Correspondence Referral System.

b) If it is clear that the correspondence or telephone call is a further question or information regarding an established case, the intermediary should handle it under its normal procedures if it has responsibility for the case or transfer it to the appropriate contractor if another contractor has responsibility for the case. "Established case" means an established MSP case – with the exception of certain HCFA identified class actions or groups, this means that there will be an established MSP record in CWF.

c) If it is not clear whether or not the correspondence or telephone call is an initial contact for a potential recovery case, CWF should be checked. The resulting information should be used to handle the correspondence under #1 or #2 above, as appropriate.

B. Liability, No-Fault, Workers= Compensation Recoveries (Activity Code 22002)

1) Designated lead contractors for liability, no-fault, and workers' compensation recoveries –

a) For liability or no-fault recoveries, the lead contractor will generally be an intermediary for the State of the beneficiary's residence. National intermediaries may be assigned a State(s) where they have a significant workload. The list of lead contractor assignments can be found in Attachment 7) "Beneficiary residence" will be determined by the existing CWF rules for beneficiary residence. Lead responsibility for the case will remain with the initial lead contractor even if the beneficiary subsequently changes his/her permanent residence.

b) For workers' compensation recoveries, the lead contractor will be the same as the lead contractor would be for a liability or no-fault recovery **except** where venue for the workers' compensation claim is in a different State. In this situation, if the beneficiary and/or his attorney or other representative identifies the State of venue at the time of the original inquiry or other notification (through an L-365 or some other communication), the COB contractor will forward the lead to the designated intermediary for the State of venue. If a contractor has the lead based upon the State of the beneficiary's residence and it is subsequently determined that the State of venue is a different State, the initial lead intermediary will transfer the lead to the designated intermediary for the State of venue and advise the COB contractor of the identity of the new lead contractor.

Note: The State of venue is the State under whose rules the workers' compensation case is being adjudicated.

c) HCFA may continue to designate a specific lead contractor for a particular group or class of recoveries (for example, as HCFA has done for certain product liability recoveries).

d) For FTCA cases, the lead contractor will be the same as the lead contractor would be for a liability or no-fault case. Please note that although a lead contractor is being designated for FTCA cases, these recoveries will continue to be the responsibility of HCFA Central Office (CO) staff. The responsibility of a lead contractor for FTCA cases will be to identify Medicare's recovery claim amount and to coordinate/facilitate communications with other intermediaries and carriers, as required by HCFA CO.

e) These requirements concerning designated lead contractors apply to all cases where the MSP record is established through the COB process as specified in the MSP pre-pay BPRs. It is critical that lead contractors establish any applicable MSP records for existing cases by 1/1/2001. Established cases will not be transferred on the basis of these new criteria.

f) Both lead and non-lead contractors must cooperate and coordinate with the COB contractor, as appropriate.

g) When the lead contractor receives information from the COB contractor that workers= compensation, no-fault, or liability insurance may have primary payment responsibility for services provided to a specific Medicare beneficiary, the lead contractor must develop, as appropriate, and pursue recovery. (Note: The COB contractor will issue the initial notice of potential Medicare recovery letter and request any necessary beneficiary release(s) in conjunction with this notice.)

h) If the MSP occurrence has been established in CWF but the lead contractor decision has not been made as of January 1, 2001, the affected contractors should use the list of lead contractors and confirm with the designated lead contractor that it has responsibility for the case and issue. As stated above, if the MSP occurrence has not been established as of January 1, 2001, the instructions for referral to the COB contractor (including the forwarding of all associated documents to the designated lead contractor) must be followed.

2) Intercontractor Notices (ICNs):

a) Non-lead contractors must co-operate with lead contractor ICN requests.

b) Non-lead contractors must respond to initial and interim ICN requests within 30 calendar days of the receipt of the request (corporate mail stamp date). The lead contractor may grant a 15-day extension, if appropriate.

c) Non-lead contractors will have 10 days to respond to a final ICN update request once there has been a settlement, judgment, or award.

d) A beneficiary release is not required in order for a non-lead contractor to respond to the ICN of the lead contractor.

C. Non-Data Match Group Health Plan (GHP) Recoveries (Activity Code 22002)

1) If a GHP specifically acknowledges that Medicare made a mistaken primary payment for a specific service and specifically acknowledges that it should have or did make a primary payment, recover the Medicare primary payment from the GHP or the

appropriate party (beneficiary, provider or supplier). Send the recovery demand letter within 30 calendar days of receiving the GHP acknowledgement.

2) In the absence of such specific information, within 60 days of the establishment of a new CWF MSP auxiliary record by the COB contractor, a contractor is obligated to search history within the established MSP period and send a demand letter (if the history search identifies potential mistaken primary payments that equal or exceed $1000) to the employer which sponsors or contributes to the GHP. Intermediaries are not to recover from the provider, unless the provider has received a duplicate primary payment from the GHP and Medicare.

See the regional office instructions based on the Lisa Vriezen memos dated August 28, 1996, November 25, 1996, December 15, 1996, August 29, 1997, and PM AB 98-6 (reissued as AB 98-68 dated November 1998.)

D. Data Match GHP Recoveries (Activity Code 22003)

1) See the regional office instructions based on the Lisa Vriezen memos dated November 25, 1996 and the August 29, 1997, but make the following changes:

a) Change the date from January 1, 1997 to August 5, 1997 wherever the January 1, 1997 date appears. Due to the enactment of the Balanced Budget Act of 1997 (BBA 1997), for all services on or after August 5, 1997, Medicare has a minimum of 3 years to initiate recovery without regard to a plan=s timely filing requirements.

b) Amend the next to last sentence in item 2(a)(ii) on page 2 of the November 25, 1996 memo to read, ASend an initial demand letter within 60 days of receipt of a Data Match cycle tape from HCFA or its agent, to the employer. Intermediaries are not to recover from the provider, unless the provider has received a duplicate primary payment from the group health plan and Medicare.≅

2) MPaRTS update:

a) The contractor is to update MPaRTS, as appropriate, depending on the factual situation, within the lesser of: 1) 30 calendar days from receipt of a response to a data match demand letter or other information affecting a data match case; or 2) 10 calendar days from completion of the evaluation of the information received relevant to the case.

b) Clarification of the 10 and 30 calendar days: 1) contractors must update MPaRTS with the appropriate code within 10 calendar days of the run date of a Data Match cycle tape; 2) the date the information is received by the contractor (most often reflected by a date-stamp in the contractor's corporate mailroom) would act as the start date when information is received through the mail; and 3) the date of the call would act as the start date when information is received by telephone. Where the start date is the mail receipt date, the initial receipt date by the contractor is controlling. (Example: Mail is received in the contractor mailroom on 12/1/99 and by the MSP unit on 12/3/99. The start date is 12/1/99. This would be true even if the contractor's mailroom is at a different address than the location where the inquiry or other information is processed.)

3. Special Projects - MSP Prepay and Postpay activities 22001 through 22006

Implement special MSP projects pursuant to specific instructions that HCFA may issue.

Workload

The Postpayment workload (Workload 1 in CAFMII) for Activity Code 22002 is the cumulative workload reported as the sum of Line 3 plus Line 5, Total Column of the HCFA-1563.

The Recoveries from IRS/SSA Data Match (Activity Code 22003) workload unit of measure for Data Match is the report identification (RI) number. This is the number used in the Mistaken Payment Recovery Tracking System (MPaRTS). Report this workload (Workload 1 in CAFMII) when all claims associated with a RI number have been:

- Researched and a demand letter issued.
- Researched and no further action can be taken at this time because of dollar tolerances.
- Researched and a determination is made that there are no claims Medicare paid as primary or your records do not indicate any claims; or
- Researched and the contractors can take no further actin on a RI number because of pending litigation or other instructions by HCFA to suspend recovery actions.

MSP - INQUIRIES - (ACTIVITY CODE 22004)

Include the costs associated with pre-pay and post-pay MSP inquiry activities.

The MSP Inquiries workload is the cumulative sum of telephone and written inquiries responded to by the MSP staff.

MSP - OUTREACH - (ACTIVITY CODE 22006)

Include the costs associated with pre-pay and post-pay MSP outreach activities.

The MSP Outreach workload is the cumulative number of outreach presentations performed.

FY 2001 BUDGET AND PERFORMANCE REQUIREMENTS
MEDICARE INTEGRITY PROGRAM

Benefit Integrity (Intermediary)

Our Program Integrity goal is to strive in **every** case to pay the right amount to a legitimate provider for covered, reasonable, and necessary services provided to an eligible beneficiary. To achieve this goal, we follow four parallel strategies: 1) preventing waste, fraud, and abuse through effective enrollment and through education of providers and beneficiaries; 2) early detection through, for example, fraud detection tools and post-pay data analysis; 3) close coordination with our partners, including contractors and law enforcement agencies; and 4) fair and firm enforcement policies.

Additionally, contractors should continue to develop and successfully implement the following during FY 2001. An enhanced Benefit Integrity (BI) staff program that will attract, train, and retain qualified professional staff in the BI area. Fraud investigators are required to take Level I and Level II training. Level I training should be completed one time only, and within one year of hire for new employees and within one year of this BPR for current employees who have not previously completed this training. Level I training consists of a total of 36 hours: 16 hours of fraud detection techniques; 4 hours of interviewing techniques; and 16 hours of data analysis. Fraud investigators who have completed Level I training before FY 2001 must complete Level II training during FY 2001. Level II training consists of a total of 6 hours of advanced training; 4 hours of fraud detection techniques; and 2 hours of advanced data analysis. This Level II training will be required each fiscal year. Additionally, the BI unit must send appropriate representatives to the national benefit integrity training hosted by HCFA. The OIG Report OEI-0397-00350, dated November 1998 noted that most intermediary fraud units developed few cases proactively and did not identify program vulnerabilities. (Vulnerabilities are defined as situations where questionable and improper Medicare payments are being made because of a legal loophole or because of systems' limitations that can't be corrected by the contractor. Individual fraud cases should not be reported as Program vulnerabilities. Vulnerability reports should be submitted to the HCFA CO and RO.) You must continue implementation of a Quality Improvement (QI) program. The QI program must ensure that the decisions made by the fraud unit are effective in preventing, detecting, and deterring Medicare waste, fraud and abuse; and that appropriate corrective actions have been employed for systemic problem areas. We suggest that the contractor conduct routine follow-ups to ensure that the corrective actions are accomplishing the goals. In addition, timely actions are essential to ensure the efficiency and effectiveness of the Program. Delayed corrective actions may: 1) permit an unsafe situation to prevail, 2) de-emphasize the seriousness of the problem, and 3) diminish the deterrent effect. Contractors must submit a report of findings for the QI program. This report must be submitted 30 days after the close of the second and fourth quarters. This report must be entitled "Benefit Integrity Quality Improvement Program." The report must be submitted to the regional office and copied to the central office at POB@cms.hhs.gov . We expect the contractor's budget request to reflect these priorities.

The BI Budget and Performance Requirements (BPRs) are the basis for the Contractor Performance Evaluation (CPE) for Benefit Integrity Units. The BI BPRs represent the increased focus on prevention, early detection, and multi-component and agency coordination. HCFA=s national objectives and goals of the CPE are: 1) Identify and use a variety of methods to detect and identify fraudulent activities; 2) Increase the use of a variety of methods, in addition to referral to law enforcement, to protect the Medicare Trust Fund in potentially fraudulent or abusive situations; 3) Improve the quality of case referrals to law enforcement; and 4) Improve the working relationships between contractors and law enforcement.

Although many of the safeguard activities are located in the BI unit, the contractor as a whole is responsible for protecting the Medicare Trust Fund against waste, fraud, and abuse. Intermediary budget requests should ensure implementation of all standards in the Contractor Performance Evaluation (CPE), all Program requirements in MIM 3950ff or the future Program Integrity Manual, and all requirements specified in this document.

Each intermediary should provide the supporting documentation requested in Attachment 5 of the FY 2001 BPR. Attachment 5 requests contractor specific narrative, workload, and cost data for FY 2000 and FY 2001.

Medicare Fraud Information Specialist (MFIS) (Activity Code 23001):

The MFIS has overall coordinating responsibility for ensuring that fraud-related information is shared with appropriate parties in their assigned areas. The MFIS should conduct regular conference calls (individual or as a group) with all contractor Fraud Unit Managers within their jurisdiction. In addition, contractors who do not have an MFIS located onsite are responsible for fully utilizing the services of the MFIS assigned to them. The MFIS should be helpful setting up meetings with provider and beneficiary groups and in obtaining presenters from other agencies and materials for these discussions. The MFIS is also responsible for the dissemination of information and networking with HCFA=s partners. The MFIS should focus on support and training for Harkin Grantees.

The MFIS should not perform activities such as complaint resolution, case development, OIG Hotline referrals, FID entries, data analysis, IRP entries, or onsite audits.

For clarification of the MFIS position description, RO accountability, and MFIS assignment, refer to CR 1172, effective October 1, 2000.

Report all costs associated with MFIS activity in Activity Code 23001. (This applies only to contractors who are currently funded for the MFIS position; no new MFIS positions will be funded.) Your FY 2001 budget request should include your work plan and level of activity for all training and outreach functions.

Report the number of fraud conferences/meetings coordinated by the MFIS in workload column 1; the number of fraud conferences/meetings attended by the MFIS in workload column 2; and the number of presentations performed for law enforcement, ombudsmen, Harkin Grantees and other grantees, and other HCFA health care partners in workload column 3.

Fraud Complaint Development and Other Lead Activities (Activity Code 23002):

Only fraud complaint development costs should be included in this activity (do not include any case development costs in this activity). Once the initial complaint has been closed, if additional costs are incurred to develop a case related to that complaint, those additional costs should be charged to Activity Code 23005.

The BI unit should take all necessary actions to fully develop, consistent with work priorities, potential fraud leads (e.g., fraud alerts, internal and external contractor referrals, Office of Inspector General (OIG) hotline calls, Fraud Investigation Database (FID) leads, and fraud complaints such as Operation Restore Trust (ORT) referrals from the States or Regions).

A fraud complaint is an allegation of fraud or abuse committed by a provider, beneficiary or other individual or entity against the Medicare program.

The BI unit should only receive and develop complaints that are likely to indicate fraud and abuse situations. The clearinghouse function (i.e., screening of incoming inquiries: written, telephone, or walk-in) must not be performed by the BI unit, but costs can be allocated to BI if they are fraud related. The BI unit should return to the appropriate contractor unit (e.g., Customer Service unit) any complaints, that are not fraud and abuse situations. Refer to MIM 3966.1 for acknowledgement of complaints.

Note: Each contractor must use the AIRP (Incentive Reward Program) tracking database≅ to support receiving and tracking fraud and abuse complaints related to the incentive reward program.

Report all costs associated with fraud complaint development in Activity Code 23002. Report the number of fraud complaints alleging waste, fraud, and abuse referred to the BI unit in workload column 1, the number of fraud complaints closed in workload column 2, and report the number of workload column 2 fraud complaints which resulted in an overpayment collection in workload column 3.

Outreach and Training Activities (Activity Code 23004):

Include costs associated with establishing and maintaining waste, fraud, and abuse outreach and training activities for beneficiaries (excluding MFIS). Beneficiary outreach activities are described in MIM section 3958. Beyond the activities in section 3958, training activities are limited to:

< Providing waste, fraud, and abuse training to new and existing BI fraud unit contractor staff.

< Providing waste, fraud, and abuse training to non-BI contractor staff.

< Participating in training developed for law enforcement agencies, including the Federal Bureau of Investigation.

< Providing waste, fraud, and abuse outreach presentations to beneficiaries (including respective associations).

Report all costs associated with waste, fraud, and abuse outreach and training activities for contractor staff and beneficiaries in Activity Code 23004. Report the number of training sessions furnished only to BI staff in workload column 1, the number of face-to-face presentations made to beneficiaries in workload column 2, and the number of training sessions furnished to non-BI contractor staff in workload column 3. Provider education and training activities related to Medicare Integrity Program (MIP) activities can be performed by BI, but costs must be reported on the MIP-PET line.

Note: 1) a training session is the presentation of a topic regardless of the number of attendees; 2) a training session which exceeds more than one day is counted as one session; and 3) the same training session which is repeated at a later date should be counted as a separate session.

Fraud Case Development Activities (Activity Code 23005):

A case exists when the contractor has substantiated an allegation that a provider, beneficiary, supplier, or other subject: (a) is suspected of intentionally engaging in improper billing, (b) submitted improper claims with actual knowledge of their falsity; or (c) submitted improper claims with reckless disregard or deliberate ignorance of their truth or falsity. The contractor's substantiation of the allegation is the verification of the information. However it is not the proving of the information in a court of law. Contractors do not prove fraud, this action is within the purview of the Department of Justice. This determination is made regardless of dollar threshold or subject matter.

In addition to developing a case based on complaints and other leads outside the contractor environment, the BI unit is expected to perform proactive data analysis (MIM 3953D) by concentrating efforts on those areas that have the highest impact for potential fraud; and by self-initiating, fully developing, and referring potential fraud cases to law enforcement. Fraud case development must follow the guidelines in MIM 3900ff, and include the use of a proactive data-based analysis to identify patterns of potential waste, fraud, and abuse. The development and referral of potential fraud cases to law enforcement must be accomplished in a way compatible with the contractor=s mission of minimizing losses attributable to waste, fraud, and abuse to the Trust Fund.

Report any costs associated with fraud case development and FID entries in Activity Code 23005. Report the total number of cases opened in workload column 1. Of the cases reported in workload column1, report how many were opened the contractor based on contractor self-initiated proactive data analysis in workload column 2. Report the total number of cases closed (no longer requiring fraud development) and which were not referred to Office of Investigations Field Office (OIFO) in workload column 3. Referred cases are defined as those meeting the requirements of MIM 3968. Matters should be referred to the OIG when the contractor has a reasonable basis to suspect that the provider (a) intentionally engaged in improper billing, (b) submitted improper claims with actual knowledge of their falsity, or (c) submitted improper claims with reckless disregard or deliberate ignorance of their truth or falsity. The OIG has 90 calendar days to accept the referral or reject the case. Whenever the contractor contacts the OIG to inquire whether the OIG will accept a case referral, the contractor should document the call as a referral in the FID, including subsequent acceptance or rejection documentation of the case. (The first call should be documented as a referral; subsequent calls are follow-ups.)

Law Enforcement Support Activities (Activity Code 23006):

Intermediaries may receive requests from the OIG, other Federal agencies, State, or local law enforcement for data and documents related to potential or ongoing audits, civil or criminal health care fraud investigations. All non-routine requests from law enforcement for intermediary assistance should be in writing. The request should outline the specific task and level of effort to be performed by the intermediary and the associated law enforcement project/case number. If the number cannot be associated with the request, the intermediary should discuss the request with the RO prior to initiating any action.

The intermediary should comply with routine written requests from law enforcement for data, documents, and assistance. When a request is received, the intermediary should prioritize it based on the type of request (critical request vs. routine request) and the amount of resources it requires. The intermediary is encouraged to discuss routine written requests it receives from law enforcement in order to identify the requestor's specific needs. Such discussions will alleviate any unnecessary burdens on both the intermediary and law enforcement agencies.

For work done to support law enforcement, report all BI costs and related data analysis costs in Activity Code 23006. Report the total number of law enforcement requests in workload column 1, report the number of requests discussed with the RO in workload column 2, and report the number of BI law enforcement requests that require data analysis in workload column 3.

Other Activities:

Additional BI unit responsibilities not separately funded or reported above include:

< The FID must be updated on a quarterly basis after the case has been referred to law enforcement.

< Keeping your regional office apprised of significant investigations within your jurisdiction.

< Taking steps to ensure that services provided by or ordered by those persons or entities who have been excluded from Medicare, are not being billed to the Medicare program during the period of exclusion.

FY 2001 BUDGET AND PERFORMANCE REQUIREMENTS
MEDICARE INTEGRITY PROGRAM

Audit (Intermediary)

In FY 2001, funding for provider audit and provider reimbursement will be tracked by the Contractor Audit and Settlement Report (CASR), the Provider Reimbursement Profile (PRP), and the Schedule of Providers Serviced (SPS). Fiscal Intermediaries (FIs) must complete the aforementioned reports and submit them to HCFA=s mainframe computer through the CASR system. Instructions for transmission are contained in the CASR User=s Manual.

General Instructions (Activity Codes 26001, 26002, 26003)

- FIs must complete the Budget Request (CASR, PRP, and SPS) in accordance with the instructions contained in HCFA PUBLICATION 13-1, CHAPTER 2, SECTION 1270 to 1274.

- FIs must complete a supporting worksheet which shows the details of their calculation of all data shown on the CASR and PRP. FIs are to use available time records to support the hours indicated. These data can be extracted from the STAR system, if necessary. The supporting worksheets are to be maintained in the FI=s files for review or submission to HCFA at a later date.

- Each FI=s budget is to furnish sufficient funding to complete all required desk reviews, audits and settlements.

- Audit Quality - FIs must continuously strive to comply with all audit standards and instructions, especially those regarding audit techniques, implementation of adjustments, and the expansion of audits based on preliminary findings and managerial review. Each audit must address the issues identified for field review by properly performing all necessary audit steps and procedures, and documenting them in properly prepared and supervisorial reviewed audit working papers.

- HCFA has made it a priority to concentrate its audit efforts on reimbursement areas that it considers to be high risk. For all provider types, the Medicare contractor should concentrate audits to areas where inappropriate cost shifting could occur. Specific attention should be given to bad debts, organ procurement costs, indirect and direct medical education, disproportionate share, and allocations between providers and subproviders.

- In major teaching Hospitals, the contractor must concentrate on Disproportionate Share, Graduate Medical Education, Indirect Medical Education, excluded units and outpatient costs.

- HCFA has identified the following workload goals based on an internal risk assessment and priorities established by recent legislation. The following represents the national audit level targets for the given categories.

Provider Type	Level of Audit including Focused Reviews
End Stage Renal Dialysis Audits (Remaining FY 1996 audits for free standing providers not completed in FY 1999)	33.3 %
Home Health Agency Audits--Free Standing	12.5%
Hospital Multi-Facility PPS (Priority goes to facilities with an HHA subprovider and large Teaching	20.0%

Hospitals)	
Hospital single facility	25.0%
Hospital multi-facility --Non PPS	25.0%
Chain Home Offices	30.0%
Certified Mental Health Center (CMHCs)	50.0%
Skilled Nursing Facilities (SNFs)--Over 10 % Medicare Utilization & over $300,000 in reimbursement	30.0%
Other—including Rural Health Clinics(RHCs)	10% or less

These percentages will be modified if the base year audits planned for any PPS rate setting activity change.

NOTE: WHILE IT IS ANTICIPATED THAT THESE PERCENTAGES WILL BE ATTAINED NATIONALLY, ROs AND FIs WILL NEGOTIATE BUDGETS BASED UPON EACH FI=s PROVIDER MIX AND OTHER AUDIT SELECTION FACTORS. HCFA CO SHOULD BE CONSULTED PRIOR TO ANY FINALIZATION OF INTERMEDIARY BUDGETS.

Provider Audit Budget Development - General Guidelines (Activity Codes 26001, 26002, 26003)

FIs should attempt to optimize the audit budgets by ascertaining risk, in conjunction with the HCFA stated goals, and utilizing focused audits wherever possible. This will allow FIs to optimize the funding available and impact more at risk program dollars. FIs should continue to expand their use of limited desk review procedures.

The selection of providers to be reviewed/audited should be sensitive to the amount of Medicare payments at risk, new providers, etc. Emphasis should also be placed on the weighted number of full-time equivalent interns and residents claimed by teaching hospitals. As discussed below, it is essential to perform Acyclical≅ reviews of those providers whose cost reports will not be subject to a full desk review. This cyclical effort is necessary to maintain the sentinel effect of the audit process. The examinations may be performed as an audit or focused review.

Each Contractor should consider the following risk profiles when selecting providers for review/audit, in addition to the National Goals:

- Hospitals with organ procurement costs of $500,000 or more. HCFA agreed to prioritize the audit of these facilities in response to findings issued by Office of the Inspector General.

- Hospitals whose Medicare reimbursement is $15 million or more. Concentrate on the largest teaching hospitals and multi-facility hospitals. Special attention should be given to those facilities where inappropriate cost shifting to subproviders or provider based units could occur. In addition, special emphasis must be placed on the audit of the Medicaid days for the DSH adjustment to insure that the program is paying properly for this passthrough cost. You should also place special emphasis on the intern and resident counts for GME, and make this area a highly focused area for all teaching hospital audits. Additionally, you are to focus your audit on the claimed observation bed days to insure that the provider has counted those days in accordance with regulations and program instructions.

  Those hospitals with hospital based HHAs should be given priority and the fiscal intermediaries should give special attention to those hospitals that have management contracts for the administration of their HHAs. The FI should concentrate on reviewing the management contracts and comparing the services rendered by the management contract to the HHA with the costs allocated to the HHA from the hospital to insure that there is no duplication of payment for costs claimed twice. In addition, the FIs must look to insure that the proper allocation of overhead to the HHA is occurring and that the HHA actually utilizes the cost that is being stepped down to it. For those hospitals with Hospital Based SNFs, the FI should insure the proper allocation of costs from the hospital to the SNF. In addition, the FI should insure that the allocation of costs in the SNF between distinct part and non-distinct part is properly shown. As part of your review of the provider, you are to inquire as to whether or not the provider maintains a reserve cost report, and you are to request the reserve report if they state that one is being maintained.

- Freestanding Home Health Agencies whose Medicare reimbursement is $1 million or more and Medicare utilization is at least 55 percent. The FI is to look at the liquidation of liabilities to insure (1) that the provider has liquidated those liabilities timely in accordance with regulations and manual instructions, and (2) that the accruals that were made at the end of the year were proper. In addition the FI is to insure that when the accruals were liquidated that the provider did not claim those costs again as an expense. The FI is to insure that if there is a management contract that there is no duplication of costs with those services provided by provider personnel. In addition, if the provider is receiving an allocation of overhead from a related hospital, the FI is to insure that the costs allocated are proper, and are not duplicative of those costs incurred by the HHA in the performance of their operations. The FI is to insure that all costs incurred between related organizations are reflected on the cost reports of the HHAs as the cost to the related organization and not the charge incurred from the related organization.

- Skilled Nursing Facilities whose Medicare reimbursement is $300,000 or more and Medicare utilization is at least 10 percent. Also, give priority to those SNFs which have any subprovider units. Focus audits on those SNFs who have significant therapy costs to insure that the costs are reasonable and what a prudent buyer would

pay. In reviewing respiratory therapy, the FI is to insure that those therapy services are performed by hospital staff. In addition, the FIs are to review the allocation of cost between the Certified and Non-Certified areas to insure that the provider has the proper documentation to reflect this separation of costs. If the documentation is not acceptable, then the areas are to be collapsed into one unit. It must be noted that HCFA does not have a zero tolerance in this area, and the FI is to insure that the reason for the collapse to a per diem is fully justified.

- Give Priority to Chain Home Office audits for those chains that have significant cost reimbursement or can shift costs through more sophisticated allocation methods. Focus the audits toward those chains with more cost based units and large Home Health Agency Chains where there are franchises. The FIs are to insure that the chains are properly allocating costs to the providers in the chain in a manner approved by HCFA. Determine that you are able to account for all related organizations and ask for a letter of representation that the home office has disclosed all organizations that are related to it. In addition, the FI is to review the due to and due from accounts on the home office trial balance to insure that the home office has not directly assigned cost to providers in an improper manner.

- Community Mental Health Clinics are to be audited to insure that all costs claimed are reasonable and necessary and are related to patient care and that the statistics used to allocate and apportion cost are appropriate and accurate.

- End Stage Renal Disease Facilities are to be audited in accordance with BBA requirements. The FIs are to insure that the final third of all fiscal year 1996 ESRD facilities are reviewed in FY 2001. The following criteria are to be used--the facilities are over the composite rate and render large numbers of treatments. Supplemental instructions to the audit instructions already issued concerning audit and desk review procedures will be forthcoming.

- Rural Health Clinics that share offices with Physician Offices are to be audited to insure that the proper costs are allocated to the Medicare cost report and that these reports are not charging the program for costs that are not program related.

- Any Audit Initiatives that the contractor or the regional offices believe should be included that differ from the National Targets or above profiles, must be explained in detail.

The number of field audit hours required for PPS Hospitals, TEFRA Hospitals, SNFs, HHAs, and other providers should reflect the estimated time necessary to complete an audit in accordance with HCFA=s guidance regarding the implementation of Government Auditing Standards.

Audit supervisors and staff are required to receive 80 hours of training every 2 years in order to comply with the revised Government Auditing Standards, which were effective January 1, 1989.

FIs are no longer required to comply with the TEFRA and PPS audit review guidelines contained in Sections 4117 and 4118 of HCFA PUB-13-4, Medicare Intermediary Manual. These guidelines will be removed from the manual. FIs should identify and settle all reopened cost reports for which additional information is not required; e.g., providers with home office adjustments, requests from providers, reopenings from appeals decisions, etc. Reopenings should be initiated where appropriate in accordance with the clarifying instructions issued to all FIs on September 27,1995. FIs must insure that all provider cost reports which still require Home Office Cost Statement finalization have been reopened in accordance with program requirements.

Field audits must include the review of a provider=s documentation to support the Form HCFA-838, Medicare Credit Balance Report. The applicable hours to complete credit balance reviews are to be included in the total number of hours needed to perform an audit.

<u>Provider Audit Budget Development - Specific Guidelines</u> (Activity Codes 26001, 26002, 26003)

FI budget requests should be prepared based on the following guidelines.

Desk Review (Activity Codes 26001, 26003)

FIs are directed to complete an Acceptability CheckList for each cost report received and compare specific provider characteristics to established Uniform Desk Review (UDR) Waiver Thresholds. Based upon these procedures, it is estimated that many provider cost reports can proceed to final settlement without desk review. In addition, provider cost reports that pose minimal risk to the program are subjected to a Alimited≅ desk review and are final settled at a significantly lower cost. On a national average , the cost of performing the check list and thresholds process is estimated to be about $700, which may vary due to regional cost variations, FI provider mix, etc.

An issue critical to the elimination of certain desk reviews is Acyclical≅ provider reviews. In order to maintain the integrity or sentinel effect of the desk review and audit process, contractors must visit a sample number of providers whose cost reports are not subject to desk review pursuant to the check list/threshold process described above, and review the cost and statistical records supporting the data shown on the cost report. The visits may be conducted as a focused review or an audit. The number of cyclical reviews that are performed as well as the extent of each review is based upon the contractors= discretion. The specific intent of cyclical reviews is to provide an opportunity for any provider=s records to be selected and examined by a Medicare auditor. (All contractor budgets and workloads must strictly comply with this requirement.)

Focused Review (Activity Codes 26001, 26002, 26003)

For FY 2001, all reviews/audits will be either Focused Reviews or Audit. During FY 2001, funding is available for each FI, with RO approval, to perform focused reviews in order to address payment issues which may adversely affect program payment. In general, an FI selects specific issues to be addressed through focused review, by provider type, prior to the start of the fiscal year; develops a review guide strictly limited to the pre-selected issues; and limits their review to the selected areas. The FI is to perform a limited desk review on those providers selected for focused review. If a provider=s focused review turns into an audit, the FI is to then perform a full desk review on those cost reports. FIs will spend audit time only on the issues targeted for review. If the other issues noted are material and cannot be corrected during the focused review process, the FI should consider scheduling the provider for audit.

Overall, it is estimated that focused reviews average about 90 hours, although the actual amount of time will vary depending upon the complexity of the reimbursement issues selected, the types of providers involved, etc.

ROs and FIs have a wide range of flexibility in negotiating focused review workloads; although, we anticipate that most focused reviews will address issues at hospitals, SNFs, HHAs, CMHCs and RHCs.

ROs and FIs may agree to focus on other provider types, limit their reviews to one provider type, or even agree to change the pre-selected issues during the year. The main idea is that the reviews focus on a limited number of issues selected by the FI based upon its discretion. However, HCFA CO would like to participate in discussions with the ROs and FIs when preselected areas are changed in order to provide any assistance to the process.

The total number of focused reviews planned to be performed is expected to be more than the number of focused reviews performed in FY 2000, since the total amount of funding available for audit activities has increased.

Field Audit (Activity Codes 26002, 26003)

We understand that variations in field audit unit cost may result from the size and complexity of an individual FI=s provider mix, geographical wage differences, etc.

It is expected that the use of Afield audits≅ be at least the same level as in FY 2000. As in the past, each cost report is to be settled at the conclusion of the audit work.

HCFA is in the process of revising its expectations for Medicare contractors in the area of cost report audit and settlement activities. HCFA will provide specific instructions to increase the timeliness of cost report settlements. These instructions will also provide guidance and instructions to both Medicare contractors and providers for conducting timely and efficient audits of cost reports. HCFA is proposing that the new process will be effective with cost report audits beginning on or after September 1, 2000.

HCFA is also expecting that the Medicare contractors should step up their process for auditing terminated providers in a more timely fashion. This means that the audits should be conducted in accordance with program instructions and that the cost report be settled in a timely fashion to ensure that all payments and debts are liquidated as fast as possible.

Workload

Desk Reviews (Activity Code 26001)

Include in line 2a of the CASR IER (CIER) the total number of units (cost reports) when the desk reviews are completed. The total number of units (line 2a) is the total of lines 3a (limited desk reviews) and 4a (full desk reviews). This count (line 2a) is the same as, and should be reported as Workload 1 in CAFM II (HCFA-Activity Code 26001) and does not include any count for provider-based facilities.

Field Audits (Activity Code 26002)

Include in line 6b the total unit count for all audit types – line 7b(focused audit), line 8b (field audit), and line 9b (onsite reviews) - for procedures performed on a cost report. An audit includes all work efforts subsequent to the completion of the desk review up to, but not including, the reworking of the cost report. The units shown in line 6b should be reported as Workload 1 in the CAFM II (Activity Code 26002).

Settlements (Activity Code 26003)

Include in line 10a the number of cost reports settled. A cost report is settled when the NPR is mailed or transmitted. This should be reported as Workload 1 in CAFM II (HCFA – Activity Code 26003). Settlements include work performed on a cost report after the completion of the desk review, problem resolution, onsite reviews, or audit, and after the exit conference.

FY 2001 BUDGET AND PERFORMANCE REQUIREMENTS
MEDICARE INTEGRITY PROGRAM

Provider Education and Training (Intermediary)

The Medicare Integrity Program Provider Education and Training (MIP-PET) Budget and Performance Requirements (BPRs) reflect the principles, values and priorities of the Medicare Integrity Program. Program Integrity's primary goal is to pay claims correctly. In order to meet this goal Intermediaries must ensure that they pay the right amount for covered services rendered to eligible beneficiaries by legitimate providers. HCFA follows four parallel strategies that assist us in meeting this goal: 1) preventing fraud through effective enrollment and through education of providers and beneficiaries; 2) early detection through, for example, medical review and post-pay data analysis; 3) close coordination with our partners, including contractors and law enforcement agencies; and 4) fair and firm enforcement policies.

The MIP-PET BPR supports the Government Performance Results Act (GPRA) and the National Performance Review (NPR). The GPRA requires that Intermediaries reduce the error rate identified by the Office of Inspector General's Chief Financial Officer (CFO) audit, and reduce the Home Health error rate. Both the GPRA and NPR instruct intermediaries to increase the effectiveness and improve the efficiency of their Medical Review and Benefit Integrity programs. The FY 2001 BPR supports these goals through provider education and training activities.

Provider Education and Training is divided into two categories: Program Management Provider Education and Training (PM-PET) and Medicare Integrity Program Provider Education and Training (MIP-PET). PM-PET involves activities undertaken in order to prevent billing errors while MIP-PET is remedial and concentrates primarily on providing feedback to providers based on data analysis and medical review results. MIP-PET activities include one on one feedback for provider specific errors; community-wide feedback for widespread errors; and general information about Program Integrity activities. Usually this feedback can be provided best by the Program Integrity component most familiar with the work. For instance, medical review personnel would be able to provide the most accurate feedback concerning issues related to medical review.

The FY 2001 MIP-PET Budget and Performance Requirements concentrate on educational activities that provide feedback to assist all providers and suppliers in the detection and avoidance of waste, fraud, and abuse. It promotes education as a critical aspect in using progressive corrective action to resolving problems identified through medical review and emphasizes the use of data analysis to focus other provider education and training activities.

Costs associated with MIP-PET work products and activities should be charged to Activity Code 24001. This includes MIP-PET activities performed by the medical review and benefit integrity areas. (This code should not be charged for any PM-PET activities.)

REQUIRED MIP-PET ACTIVITIES (Activity Code 24001)

- Provide one on one feedback to individual providers/suppliers on specific problems identified through prepay and postpay medical review. Use progressive corrective action in focusing your educational activities.

- Provide feedback to the larger provider/supplier community on widespread errors. Use data analysis and the results of medical review to direct these educational activities.

- Provide general information about program integrity activities. This includes sharing of information on program integrity goals and processes with local medical societies, professional associations, and other provider/supplier organizations in order to reach as many providers/suppliers as possible.

- Issue bulletins and letters to providers/suppliers containing Program Integrity information. Unless specifically requested by the provider, eliminate special bulletins and letters to all providers/suppliers with no billing activity in the prior 12 months. Bulletins should be posted on contractor websites where duplicate copies may be obtained by providers/suppliers. (Refer to the PM-PET section for posting instructions.) All

bulletins/newsletters must have a header/footer that includes the following bolded language: **"THIS BULLETIN SHOULD BE SHARED WITH ALL HEALTH CARE PRACTITIONERS AND MANAGERIAL MEMBERS OF THE PROVIDER/SUPPLIER STAFF. Additional copies may be downloaded from our website at (insert contractor website address)."**

- Assure prompt, accurate, and courteous replies to all incoming phone calls and letters seeking educational information, clarifications, etc.

- Promote interaction and coordination among the fraud unit, medical review unit, provider/supplier enrollment unit, etc. This interaction and coordination is essential in determining the appropriate training and education that is needed to provide proper feedback to both individual and groups of providers.

OPTIONAL MIP-PET ACTIVITIES (Activity Code 24001)

As time and funding permits the following activities can be funded through MIP-PET.

- Provide remedial education to Administrative Law Judges (ALJs) about Medicare Integrity Program-related policies and administrative procedures.

- As requested participate in presentations at fraud and abuse programs arranged by health care provider/supplier groups.

- Address medical/specialty groups to answer their issues and concerns.

- Prepare/distribute computer based training modules, videos, and other materials that address Medicare Program Integrity issues.

ALLOCATION OF COSTS TO MIP-PET

Regarding any general seminars, conventions, or conferences which address fraud and abuse as well as issues outside the fraud and abuse area, the proportional share of the cost of a function to be allocated to MIP-PET is equal to the percentage of time related to addressing fraud and abuse issues, times the cost of the function.

Regarding any bulletins, letters, inserts, videos, teleconferences, or educational materials which contain fraud and abuse issues as well as issues outside the fraud and abuse area, the proportional share of the cost of any of these items to be allocated to MIP-PET is equal to the percentage of the medium related to addressing frauds and abuse issues times the cost of the letter, bulletin, seminar, etc. (e.g., if it cost $4,000 to produce and distribute a bulletin, containing 25% fraud and abuse information – the MIP-PET cost would be $1,000 and the remaining $3,000 would be charged to PM-PET).

SUPPORTING DOCUMENTATION FOR FY 2001 BUDGET

1. Identify the amount or funding included in the budget related to providing feedback to individual provider/suppliers.

2. Identify the amount of funding included in the budget related to issuing bulletins and newsletters.

3. Identify the amount of funding included in your budget request related to optional MIP-PET activities.